

As I was reading the analysis of SB-151 from the Legislative Reference Bureau and the bill itself, I was struck by several thoughts. Thank you for allowing me to share these thoughts.

I was struck by the extent at which legislators need to go to change the status of suicide: to legitimize it and make it legal. The bill declares about the terminally ill, "I will accept full moral responsibility," thus recognizing the moral (that is to say the right or wrongness of something) implications of this change. Any normal individual, in their right mind, understands the discussion of this act as suicide. Without this bill, it would still be suicide, a criminal and morally reprehensible act.

Logically, I found some difficulties with this proposal to change and legalizing suicide (And no matter how we try to cleanse and legitimize the term suicide, we must call it for what it is).

If a perfectly healthy individual were to request drugs, proceed to take them, in an attempt to end his or her life, what would we do as a society? They would be locked up in a mental ward of a hospital to discover what mental health condition they suffer. Certainly, an individual who is distressed because of their physical condition, (just mention the word cancer and notice one's reaction), is in no better mental health to request his or her death. How could a psychologist declare the one mentally ill and the other "in their right mind?"

Another question of logic about the change of the status of suicide revolves around the persons *desire* to take his or her own life. Just because I *desire* something, does not make it right! If a man *desires* more money than he has and robs a bank, should we change the laws about robbery to make legitimize it and make it legal? We are walking on a slippery slope. I believe that our society has been doing this for many years, especially since Roe vs. Wade realistically changed the killing of a baby, into the discarding of a little blob of flesh. Do we have a foundation upon which to base our walk down this path other than the desire and feelings of an individual?

Biblically, I am appalled by the attempt to change, thus legitimizing suicide. Man is created in the image of God, Genesis 1:27, "So God created man in his own image, in the image of God created he him; male and female created he them." The taking of a life is to be left in the hands of our Sovereign God. In Job 1:21 we read, "And said, Naked came I out of my mother's womb, and naked shall I return thither: the LORD gave, and the LORD hath taken away; blessed be the name of the LORD."

What is a terminal illness? Scripture and experience tell us that we all suffer a terminal illness. "Wherefore, as by one man sin entered into the world, and death by sin; and so death passed upon all men, for that all have sinned: (Romans 5:12)." You and I have never met anyone who has not or will not die. We are all terminal! When will the definition of terminal illness be redefined so that anyone might seek to end his or her life? In other states, this type of problem already exists within the medical marijuana debate. What illness is sufficient to receive the treatment? A headache?

Of course the Scriptures declare: "Thou shalt not kill" (Exodus 20:13). I will not spend any time here, since assisted suicide obviously makes the doctor an accessory to murder at the very least.

The bill also makes the proclamation that this decision to commit suicide must be and "informed decision." Only five items are mentioned as to what the person desiring suicide must be informed. That doesn't sound very informative for such a permanent decision. And as a pastor, I make just a few more suggestions. Does the person have an understanding of what happens at death? Except one raise from the dead and be a witness to the after life, they could not inform the person desiring suicide. Yes! Jesus did just that! He arose from the dead and in his very own words describes what happens to an individual after death. Please read Luke 16:19-31.

Should a clergy member be involved with these decisions, so that an informed decision can be made?

Practically, there are some difficulties regarding this change regarding assisted suicide. Doctors would be forced to disregard non maleficence (first do no harm) for their patient. Second, certainly the doctor is prohibited from further ministering for the beneficence of the patient. This bill would also drive doctors from our state in fear of prosecution for not obeying this mandate placed upon them.

"Putting out of their misery" is a term we use for animals (and I'm sure that PETA would not approve), not for man, who is created in the image of God. Hell (in the words of Jesus) is much more miserable than any pain and suffering on earth.

Let me end with a personal story. My father in law fought with MS for over 30 years of his life. I can't tell you how many people I have met that were encouraged by his struggle with this disease. Please don't allow someone to take away the value of a suffering individual by declaring their life would be better ended.

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*Respectfully Submitted*  
*Mike Mayhew*

Submitted testimony of **Michael T. Claessens, M.D.**, Palliative Medicine physician,  
M320 Galvin Avenue, Marshfield, WI, 54449,

in opposition to

**Senate Bill 151, "Death with Dignity,"**

to the Senate Committee on Public Health, Senior Issues, Long Term Care and Privacy,

January 23, 2008.

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Ladies and gentlemen, thank you for allowing me to submit written testimony in opposition to Senate Bill 151 that proposes the legalization of physician-assisted suicide (PAS). I just heard about this bill less than five days ago, and my patient care responsibilities preclude my being present with you in Madison. The views herein expressed are my own views and are not intended to represent my employer.

Allow me first to outline my background as one familiar with the issues outlined in this bill. I am a physician specialist in Palliative Medicine, the subspecialty focused on identifying, addressing, and treating areas of suffering for patients seriously ill or dying, and their loved ones. Importantly, I have had requests made to me for PAS or euthanasia. I am certified by the American Board of Internal Medicine and the American Board of Hospice and Palliative Medicine. My training has been at Dartmouth College in religion and philosophy, the University of Minnesota Medical School, Dartmouth-Hitchcock Medical Center in internal medicine, and with palliative care pioneers at McGill University and the University of Ottawa Institute of Palliative Care. I have co-authored scientific papers on the care of the suffering and dying. Since 1999, I have practiced full time Palliative Medicine in Marshfield, Wisconsin. However, I believe my most important qualification to speak to this bill is that I spend my days, and at times my nights, at the bedside of the suffering and dying, where my most important skill is listening to my patients.

The purpose of my testimony today is to oppose Senate Bill 151 based on the following:

- (1) PAS is inconsistent with the physician's responsibility to heal and care for his or her patients;
- (2) PAS is *not* a compassionate response to suffering and thus is the wrong focus of efforts toward death with dignity;
- (3) PAS does *not* represent a respect for autonomy but puts us precariously on the slippery slope leading toward involuntary euthanasia; and
- (4) The bill, as written, is pragmatically untenable even if it were acceptable in principle.

I will include for each of my first three points stories of real persons for whom I have personally cared.

First, PAS is inconsistent with the physician's role as healer, not only violating the oaths most of us have taken as professionals but effectively abrogating the special trust patients and society may have had in us. The Hippocratic Oath states that its adherents, "Will give no deadly medicine to any one if asked, nor suggest any such counsel..." Hippocrates was a Greek physician, circa 400BC, who objected to the medical culture of his day, in which euthanasia was commonplace, and wrote his oath that affirms the sacredness of life and the doctor's duty to protect it. Essential elements of the oath include the following: transcendence – the recognition of the need for a power over and above mankind; teaching within a moral ethos; a high value of human life; the importance of trust between practitioner and patient; collegiality in support of not pressuring practitioners to act against their consciences; and integrity, supporting that purity of motive and beneficence would guide practice.<sup>1</sup> These issues of trust and integrity are particularly important at a time of great vulnerability for the patient. When a patient is sick, suffering, and perhaps dying, his family and he often are looking for guidance from a health care team that is familiar with the issues they face (present and future), will listen to them, and will advise them in a trustworthy manner. They want to believe what is succinctly stated in a 15<sup>th</sup> century French proverb, that the practitioner will, "cure sometimes, heal often, and comfort always."

I would like to illustrate my first point with a story that I believe demonstrates integrity, caring and patient trust. The patient was a middle-aged man for whom I cared while still a resident in internal medicine. He had lung cancer and was transferred to the university hospital due to shortness of breath. He received diagnostic evaluation and attempt to remove cancerous fluid from around his lung. Unfortunately, we had reached the limits of our disease-directed interventions, and he was ready to return to his local hospital for ongoing care, likely with a hospice focus. While on private rounds to see him, he asked me to give him medicine to take his life. With caution and caring, I explained to him that I could not and would not do that, but I would do whatever I could to treat his symptoms and make him comfortable. The next day, he decided he wanted to stay in our hospital under my care. I found out later that his primary reason for requesting hastened death is that his wife also had lung cancer, and he did not want her to see him suffer and fear the same fate for herself. The patient requested physician-assisted death, but I believe what he really wanted was compassionate, competent care for the sake of his wife, and he was very grateful.

Secondly, PAS is *not* a compassionate response to suffering and thus is the wrong focus of efforts toward death with dignity. Without question, people suffer. Suffering knows no boundaries – it is not a respecter of person, race, gender, socioeconomic status or even ostensible good health. Suffering is personal and can be experienced in many domains – physical, emotional, spiritual, relational and many others, and it can strike any time. When suffering is present, it cries for a human response, and when it is in the context of illness it often pleads for a physician's response. Therefore, the first job is one of listening. I must sit, spend time, and listen intently to know the source of suffering. When it is physical suffering, for example severe pain, it is almost always remediable.

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<sup>1</sup> Commentary on Hippocratic Oath from Dr. John Patrick, [www.johnpatrick.ca](http://www.johnpatrick.ca).

When the suffering is non-physical, such as existential anguish, it is far more difficult, but even in such situations there is frequently some way to help. The term palliate is from the Latin root *pallium*, which means to cloak or to cover, in that even if the core problem cannot be cured or corrected it can be addressed with efforts to relieve symptoms and other burdens. In the setting of terminal illness, which is the context for Senate Bill 151, interdisciplinary palliative care and hospice teams provide the most expert response to suffering. We are not perfect, and I never promise *perfect* relief of problems; that would be foolish. What I do promise is our best efforts at addressing the problems, and the expertise and efforts of the team is almost invariably helpful to patient and family. As mentioned, existential distress is most difficult, and though it sometimes cannot be relieved it is arguably not a strictly medical issue and appropriately involves people and resources in various parts of the community. Suicide may seem like a simple solution to the problems or suffering, but it may itself be a source of suffering to others. Thus, I submit that the proper response to suffering is not PAS but listening and responding to the person's needs, which in the context of terminal illness should include expert palliative care.

I would like to illustrate my second point with two patients whose stories convey hope for relief of suffering. First is the story of a man, 50 to 60 years old, whom I was asked to see because he wanted to stop kidney dialysis and die. To the referring doctor, it was pretty straightforward – stop dialysis, explain the expected course of decline, and keep him comfortable. However, when I met with him I wanted to discern what was driving his decision. He said, "The pain,... the pain. If I didn't have the pain, I would love to keep on living." So, I treated his pain successfully, and he happily continued his dialysis-dependent life. The second story of pain, though, is far more complicated but thankfully also one of relief. She was a middle-aged woman professional with an abdominal cancer, experiencing severe pain and evident anxiety. Her pain was brought under adequate control initially, but it was progressive and increasingly difficult to control. Despite having home hospice, pain management required admission to an acute hospital palliative care unit. Pain improved but persisted. Then, one day, in the course of two and one-half hours of physician at bedside with patient and family member, a source of emotional and spiritual suffering was revealed from her past, and with counseling and prayer she achieved reconciliation and healing. Her physical pain resolved completely, and she later died peacefully. Two patients; two sources of suffering; and in these cases relief was realized with expert palliative care rather than hastening death.

Thirdly, PAS does *not* represent a respect for autonomy but puts us precariously on the slippery slope leading toward involuntary euthanasia. I understand that one of the most strongly stated reasons for PAS is autonomy – the ability to self-govern or control one's own life. However, there is no place in medicine for absolute autonomy. A patient cannot demand tests and treatments and expect to always receive them, because they might not be indicated, they might not be affordable (individually or societal), and in the case of certain requests they may be against the conscience of the practitioner. *Respect* for autonomy should always be practiced, but it doesn't necessitate rote compliance with the patient's wish. But, in the case of PAS, even if it were legalized and requests granted,

I believe it would lead to *less* respect for autonomy as a society – with serious risk of involuntary euthanasia.

In delineating my rationale for PAS leading to euthanasia, I will quote a legal opinion and give an historical reference. The legal opinion is from attorney Walter Weber: "Under the equal-protection clause of the Fourteenth Amendment to the U.S. Constitution, legislative classifications that restrict constitutional rights are subject to strict scrutiny and will be struck down unless narrowly tailored to further a compelling governmental interest. ... A right to choose death for oneself would also probably extend to incompetent individuals. ... [A] number of lower courts have held that an incompetent patient does not lose his or her right to consent to termination of life-supporting care by virtue of his or her incompetency... [T]he ["substituted judgment"] doctrine authorizes – indeed requires – a substitute decision maker, whether the court or a designated third party, to decide what the incompetent person would choose, if that person were competent. ... Therefore infants, those with mental illness, retarded people, confused or senile elderly individuals, and other incompetent people would be entitled to have someone else enforce their right to die."<sup>2</sup> Thus, though Senate Bill 151 is expressly intended for competent individuals, it might not stay that way.

The historical reference alluded to above is from pre-Nazi Germany, and I use this not for fear of intended "cleansing" but of cost control. We are all aware of the looming crisis of how health care and custodial care will be provided for our aging society. I have heard it said, and believe it, that if we want to continue to care for our people the same way we do now, we could never build enough hospitals and nursing homes to care for all those who will need them. Please bear that in mind as you listen to quotes from physician Alfred Hoche and lawyer Karl Binding, both Germans, writing in reference to "life devoid of value" – i.e., mentally disabled, "ballast persons:"

- The question of whether we should spend all of this money on ballast type persons of no value was not important in previous years because the state had sufficient money. Now, conditions are different...
- Opposed to our task is the modern effort to keep alive all sorts of weaklings and to care for all those who are perhaps not mentally retarded but are still large burdens...
- ... The granting of death with dignity to life devoid of value to affect the release of the burden will for a long time be met with resistance for mostly sentimental reasons...
- In order to attain the necessary results, we must investigate... the possibility and conditions for euthanasia.<sup>3</sup>

We know the results of the years to follow, and may we heed the warnings of history.

Illustrating my third point is a story of request for assisted death by an individual on behalf of another person. I was caring for a pleasant, married woman of about 70 years

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<sup>2</sup> Walter Weber, "What right to die?" *Suicide and Life-Threatening Behavior* 1988;18:181-184, quoted in O' Steen DN and Balch BJ, "What's wrong with making assisted suicide legal?" [www.cmda.org](http://www.cmda.org).

<sup>3</sup> Quoted in, Baker R and McCullough L, "Medical ethics' appropriation of moral philosophy: the case of the sympathetic and the unsympathetic physician. *Kennedy Institute of Ethics Journal* 2007;17:3-22.

old. She had multiple myeloma with a tumor mass causing paralysis of her legs. In the course of care, she became delirious, suspected to be caused by medications and/or urinary tract infection. While she was delirious, a common source of suffering for family members watching the ill person, her husband asked one day if there were, "Anything [I] could do" [to take her life so she wouldn't suffer]. I explained to him, as I did in the first case I shared with you, that I could not and would not do that, but that we would continue to care for her and try to relieve her suffering with means available to us. Her delirium was corrected after adjustment of medications, addition of antibiotics, and some hydration. Upon becoming coherent again, the patient was directed to a friend of hers who provided specific spiritual counseling, after which she had renewed joy and peace. She seemed like a new person, and she later stated (of course never knowing of her husband's request for her hastened death), "I'm sure glad I didn't die, because I would have never known this peace." I conclude this section on respect for autonomy by communicating my hope that intentionally hastening death is never a legal option, despite the striving for absolute autonomy.

My fourth point is that Senate Bill 151, as written, is pragmatically untenable even if it were acceptable in principle, due to the procedural requirements of terminal illness, voluntariness, and competency. With regard to terminal illness, it is commonly known that even the best clinicians are poor at survival prognosis, and it is cogently argued elsewhere<sup>4</sup> that strategies to clearly define the "terminally ill" are so problematic that it precludes restricting PAS to that category of people. An Institute of Medicine report<sup>5</sup> on end-of-life issues addresses the next two issues:

- "The criterion of voluntariness also presents problems in determining patient status and articulating boundaries (e.g., what constitutes undue influence by another party). Further, the question can be raised whether serious socioeconomic disadvantage nullifies voluntariness."
- "Similarly, requiring that patients be mentally competent raises questions about what standards will be used, what threshold will be set, how fluctuating capacities will be handled, and what will be done about directions in advance."

To reiterate, even if PAS were acceptable in principle, the procedural requirements of the bill make it untenable in practice.

In conclusion, I restate my strong personal and professional opposition to Senate Bill 151 that is intended to legalize PAS. I hope I have conveyed to you my rationale and experience that PAS is inconsistent with a physician's responsibility to heal and care, is not a compassionate response to suffering, does not represent a true respect for autonomy, and is procedurally untenable. Woe to us if we choose to proceed down the path of legalizing and medicalizing elective death, for it would be a path of terrible and unnecessary consequences.

Thank you very much for your time and attention to this important matter.

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<sup>4</sup> Lynn J, Harrell FE, Cohn F, Hamel MB, Dawson N, Wu AW. Defining the "terminally ill." Insights from SUPPORT. *Duquesne Law Review*. 1996;35:311-336.

<sup>5</sup> Field MJ and Cassel CK, eds. Approaching death: improving care at the end of life. Institute of Medicine. Washington: National Academy Press, 1997.







## WISCONSIN CATHOLIC CONFERENCE

**TESTIMONY IN OPPOSITION TO SB 151: ASSISTED SUICIDE**  
**Presented to the Senate Committee on Public Health, Senior Issues,**  
**Long Term Care and Privacy**  
**January 23, 2008**

Thank you for the opportunity to testify on Senate Bill 151. My name is Barbara Sella and I'm the Associate Director for Respect Life and Social Concerns at the Wisconsin Catholic Conference.

The Wisconsin Catholic Conference is strongly opposed to this proposed legislation. Not only does it involve the taking of human life, but it also weakens rather than strengthens the bonds of human solidarity.

Assisted suicide raises questions that are profoundly personal and heart wrenching. Yet, it is in these very moments that we are most in need of principles to guide our choices and to define the limits of our actions.

The first of these principles is that human life is sacred, a gift with which we are endowed by God. Hence, it is inalienable.

This is not merely a "Catholic" proposition, nor a uniquely Christian one. It is, rather, a "self-evident" proposition, recognized as such by the Founders and reaffirmed by Lincoln at Gettysburg when he dedicated the nation to a new birth of freedom, but a freedom under God's providence.

The second principle is that human life is social. We humans, by our nature, are bound to each other. Any decision that violates basic rights or that devalues life affects other types of behavior and other choices. Such decisions are never a purely private matter or choice.

Because human life is both sacred and social, we regularly exhort our fellow citizens to embrace a consistent life ethic that calls us to evaluate all decisions in the light of their impact on human life and dignity. Physician-assisted suicide is a rejection of this ethic because it involves a direct attack on human life.

Supporters of assisted suicide stress that personal freedom means that one should be able to choose the time, place, and manner of one's own death in order to die with dignity.

If choice is what matters most, then it is difficult to justify imposing any limit on that choice. Why must death be expected in six months, as the bill provides? Why have any time limit at all?

Why limit the right to die to the terminally ill? Many chronically ill persons may be experiencing greater suffering, for a more extended period, and at greater cost to themselves, their families, and society.

If the goal of assisted suicide is to avoid pain and suffering, why limit this bill only to those who patients who are capable of making an informed choice? What about non-competent patients who are suffering and who are not capable of expressing their desire to die? What about infants?

We simply cannot go in this direction.

These concerns are not merely academic. If we look to the Netherlands, where assisted suicide and euthanasia is widely practiced, it is clear that all the scenarios outlined above have come to pass. Doctors have assisted not just the terminally ill to die, but those who are completely symptom free, those who are severely depressed, and those who have not voluntarily consented to ending their lives.

Furthermore, since the publication of the Netherlands' Groningen Protocol in 2004, the Dutch permit doctors to euthanize newborns born with serious disabilities, like severe spina bifida.

In other words, the justifications used to allow a competent person to kill himself have led to doctors killing incompetent persons.

Human freedom and personal choice are not absolute values or rights. We limit individual action when one person's unfettered choice can easily lead to the degradation or destruction, not just of her life, but of others as well. In short, the law places some limits on freedom and choice in the interest of protecting human life and dignity.

If our law does not recognize a person's choice to become a prostitute or a slave, how can it permit her to use the argument of freedom in order to be killed? Personal freedom and choice cannot trump the inalienable right to life.

It does not follow, however, that a terminally ill patient is obligated to accept or employ every means of treatment just to stay alive. Catholic moral teaching makes a clear distinction between ordinary and extraordinary means of care, between accepting death and choosing to cause it. If a patient chooses to forego aggressive (i.e. extraordinary) treatment for advanced cancer, she is not choosing death. Rather, she is choosing life without the burden of extraordinary medical intervention.

On the question of pain and suffering, there is a distinction to be made between the two.

Pain is physical and very real for the dying person. Everything possible should be done to reduce and alleviate it, and indeed, enormous strides are being made in the area of palliative care. Catholic medical ethics permits the use of powerful painkillers even when they may have the unintended side effect of shortening a patient's life.

Suffering, though very real, is not solely a matter of physical discomfort. Suffering is also a matter of emotional and psychological anguish. Persons near death anguish for their families and care-givers. Loved ones often suffer for those dying.

We can never remove all suffering without taking away our human nature. But we can ease most suffering. As individuals and as a society, we can and must comfort dying persons and reassure them that we value their continued presence. We can and must tell them that their dependency does not diminish their inherent dignity. We can and must affirm that their lives still matter.

One final concern with Senate Bill 151 is the requirement that the attending physician either fulfill the patient's request for medication to end her life or "make a good faith attempt to transfer" the patient to another physician who will provide the medication. A physician who refuses or fails to make a good faith effort to transfer shall be guilty of unprofessional conduct.

To force anyone to become complicit in a suicide is morally wrong.

For all these reasons, the Wisconsin Catholic Conference urges you to oppose this legislation.

Thank you.





# Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Senate Committee on Public Health, Senior Issues, Long Term Care and Privacy  
Senator Tim Carpenter, Chairperson

FROM: Mark Grapentine, JD – Senior Vice President, Government Relations  
Jeremy Levin – Government Relations Specialist

DATE: January 23, 2008

RE: Opposition to Senate Bill 151

On behalf of the more than 11,000 members of the Wisconsin Medical Society, thank you for this opportunity to register opposition to Senate Bill 151. Our opposition follows a basic belief that a physician has the role of a healer. While SB 151 may come with the most humane of intentions, ultimately it is in direct conflict with the physicians' role and their relationship to their patients. The Society and the American Medical Association have policies addressing this issue:

## ETH-020

**Euthanasia:** The Wisconsin Medical Society believes that the intentional termination of the life of one human being by another—mercy killing or euthanasia—is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth. (HOD, 0404)

## E-2.21 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering. It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations. Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)  
Issued June 1994 based on the report "Decisions Near the End of Life," adopted June 1991 (JAMA. 1992; 267: 2229-2233); Updated June 1996.

Thank you again for the opportunity to provide this testimony. If you have any further questions or need additional information, please feel free to contact Mark Grapentine at [markg@wismed.org](mailto:markg@wismed.org) or Jeremy Levin at [jeremyl@wismed.org](mailto:jeremyl@wismed.org). Both can be reached at (608) 442.3800.



## MINISTRY HEALTH CARE

*Sponsored by Sisters of the Sorrowful Mother*

Submitted testimony of Joseph Jarabek, MD on behalf of Ministry Health Care

In opposition to Senate Bill 151, related to physician assisted suicide (PAS)

Submitted to the Senate Committee on Public Health, Senior Issues, Long-term Care and Privacy

Wednesday, January 23, 2008

**Palliative (adjective):** *alleviating pain and symptoms without eliminating the cause.*

*Encarta Dictionary, English, North America*

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Thank you for allowing me to submit written testimony on behalf of Ministry Health Care, in opposition to Senate Bill 151. I am caring for my patients in Stevens Point today and appreciate the opportunity to share these written comments with you.

I am a physician who is Board-certified in both Geriatrics and Internal Medicine. I practice medicine in the Central Region (Stevens Point) of Ministry Medical Group—Ministry Health Care. Additionally, I am the Medical Director of two area nursing homes. In my career, I have cared for many dying patients. Providing palliative care — medical treatment for a patient facing great pain and death — also almost always involves and requires communication with family members as well.

You will certainly hear comments about physician assisted suicide (PAS) being inconsistent with the practice of medicine, and you will hear from some who will position PAS as part of providing care for dying patients. In addition to the moral aspects of the issue, I am concerned that the ready-availability of PAS may actually make it more challenging to deliver the exceptional end-of-life care that we would all want for our loved ones and for ourselves.

Many physicians have received questions about, if not outright requests for, PAS from their patients. In one national sample 18% of all physicians and 50% of oncologists reported receiving requests for PAS.<sup>1</sup> How do we answer such requests?

**The task of medicine is to *care*, even when it cannot *cure*.** As healers, physicians are called to maintain or restore health whenever possible, but when our patients can not be cured, we are called to journey *with* them, to treat pain and other physical symptoms, and

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<sup>1</sup> Emanuel EJ, Fairclough DL, Daniels ER, et al. Euthanasia and physician-assisted suicide: attitudes and experiences among oncology patients, oncologists, and the general public. *Lancet* 1996;347:1805-1810

to address suffering of all kinds. In other words, we are called to promote a kind of healing, even as death draws near.

I am pleased to be part of Ministry Health Care, a large Catholic health care system, sponsored by the Sisters of the Sorrowful Mother. Our system includes 15 hospitals (*note: includes Affinity Health, co-sponsored by Wheaton Franciscan Healthcare*), dozens of clinics and a number of affiliated services including Kidney Care and Home Care. Our delivery services include rural and underserved portions of central and northern Wisconsin, extending west into Minnesota, and east to Door County. We serve a significant number of Medicare and Medicaid patients, and we provide care to the uninsured, above and beyond the required emergency care as required by federal law.

The *Ethical and Religious Directives for Catholic Health Care Services*<sup>2</sup> tell us that, as witness to our faith...

Catholic health care institutions will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it.

In Directive 61 the Bishops are quite explicit:

Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die.....Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life, so long as the intent is not to hasten death.....

It doesn't seem right to simply oppose something without offering something preferable in its place. What health care providers can offer is **excellent symptom management** with specialists in the practice of palliative medicine, and a team approach that involves professionals who can competently address depression and suffering in all of its forms: physical, spiritual, psychological, and social. A patient raising the issue of PAS gives us an opportunity to explore the root causes and fears prompting the request and address them, to explain to the patient and family that burdensome treatments need not be accepted, to provide education on all of the options for pain control and other symptom management, and most importantly to offer assurances of our unending commitment to providing care.

Thank you, Senators, for allowing me to share my thoughts today. I respect the task before you, and hope that you will not open the door for physician-assisted suicide in Wisconsin.

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<sup>2</sup> ERD. 2001. *Ethical and Religious Directives for Catholic Health Care Services*. Washington, DC: US Conference of Catholic Bishops



## Testimony to Senate Public Hearing on SB 151, January 23, 2007

My name is Dr. Franklin Smith. I am a practicing physician living and working in the Delafield area. I serve as Vice President of the Milwaukee Guild of the Catholic Medical Association and today I speak on behalf of the Milwaukee Guild, which is opposed to 2007 Senate Bill 151, a so-called, Death with Dignity Act, more properly called, a Physician Assisted Suicide bill.

Why is this a bad bill for the people of Wisconsin? At a time when people are the most vulnerable, when they are afraid to die, it tells them, take the easy way out, you don't want to suffer. This is a huge step to take – the creation of a choice for death will inevitably create an obligation to die for many. It will say, "You don't want to be a financial burden on your family, do you? You should get out of the way and make room for others." *This* is not compassion. Compassion is solidarity and commitment; compassion requires effort to love a patient, to suffer along with a patient. It's not as easy as swallowing a suicide pill.

This bill is bad because it poisons the doctor – patient relationship. The doctor - patient relationship is a sacred alliance that reassures the patient, "My doctor will fight for me to sustain my life and obtain a cure, and if my life cannot be preserved, my doctor will offer comfort and relief of pain and stand by me in my suffering." But, on the other hand, "What if my doctor also helps kill people, where does that leave me, can I trust him or her? If my doctor says there's nothing more we can do, is this true, or is he just tired of me and my complaining? Does he just want to get rid of me?"

This bill is bad because it creates other conflicts of interest in the question of deciding whether the patient lives or dies. Money is one of the biggest. In today's climate of controlling health care costs and managed care, it's a lot cheaper to an insurer if the patient just checks out than if they have to keep paying for his or her care.

This bill is so extreme that, even if you accept the premise that physician assisted killing can be good, the bill creates an imbalance, pushing death over life, killing over caring. The bill

will hold harmless actions to help kill patients, but punish doctors who won't participate, either by direct or indirect action. Why would this carefully crafted bill push such a bias? Because the framers of this bill know doctors don't want to kill their patients. The framers are set on forcing doctors to do their lethal bidding. What is it about legislators who are so determined to push their agenda that they are set on reprimanding and punishing doctors for refusing to violate their own consciences?

In fact, in contrast to the intention of this bill, conscience protection is enshrined in the First Amendment of the United States Constitution, and in Article 1, Section 18 of the Wisconsin Constitution, which states, "Any control of or interference with conscience rights shall not be permitted."

What do the national medical organizations say? The nation's second-largest medical organization, the American College of Physicians – American Society of Internal Medicine, has declared its opposition to the legalization of physician assisted suicide. They said, "Physician-assisted suicide should not become part of standard medical care. Its routine practice would raise serious ethical and other concerns, undermining the patient-physician relationship and the trust necessary to sustain both the relationship and the role of the medical profession in society" and "We must solve the problems of inadequate care at the end of life, not avoid them through practices such as physician-assisted suicide."

The American Medical Association, the nations largest medical organization, has made it's opposition to physician assisted suicide clear:

Their official policy, H-140.952 states, "Physician assisted suicide is fundamentally inconsistent with the physician's professional role." And "Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary."

Their Code of Medical Ethics E-2.211 on Physician Assisted Suicide states, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be

difficult or impossible to control, and would pose serious societal risks".

I would also like to point out the use of euphemism and imprecise language in the bill. In addition to the misleading term, "death with dignity", the term, "terminal disease" is problematic, even adding the qualification of "causing death within 6 months". When a patient with an incurable cancer asks me, "How much time do I have?," I can give them statistics of average survival, but the range is so broad, I tell them that as soon as we predict time we are proven wrong.

I also reassure them that, with all the progress modern medicine has made, we have excellent pain medications and treatment options, but I encourage them, up front, to tell us if their pain relief is not adequate so that we can intervene. And I tell them that this phase of life, while it is frightening, is often the most productive and the most meaningful time to connect with loved ones, friends and the things that mean the most to them in life.

Finally, I understand why the so-called "death with dignity" movement seeks to eliminate the use of the term, "suicide". They have found that people recoil at the term, that it has overtones of violence and irrationality. Unfortunately, you can't change the meaning of the English language by this bill, any more than you can legislate a repeal of the law of gravity, simply by saying, "Taking medication under a fulfilled request for medication and this chapter does not, for any purpose, constitute suicide".

In summary this is a bad bill. It is built on fear, rather than compassion. It says it preserves dignity in dying, but it will really be about preserving dollars by promoting death. It purports to offer choice to patients, but it is really about penalizing doctors who won't go along with the new game plan. Why would you want to force someone to do something they don't want to do, and that they know is wrong? It is poison to the sacred relationship between Wisconsin doctors and patients. When all doctors are required to kill, only killers will become physicians. That is not the kind of doctor I want for my medical care.

Thank you very much.



# Pro-Life Wisconsin

*Defending them all...*

P.O. Box 221 Brookfield, WI 53008-0221  
Phone (262) 796-1111 Fax (262) 796-1115  
info@prolifewisconsin.org www.prolifewisconsin.org



For immediate release  
January 22, 2008

Contact: Matt Sande, Director of Legislation, (262) 352-0890  
or Virginia Zignego, Director of Communications, (262) 796-1111

## **Senate Committee to Hear Assisted Suicide Bill**

*Pro-Life Wisconsin to send message that Wisconsin stands for life, not death*

The Senate public health committee will hold a public hearing Wednesday, January 23, on Senate Bill (SB) 151, legislation legalizing physician-assisted suicide (PAS) in Wisconsin. Pro-Life Wisconsin strongly opposes SB 151 and will publicly testify against the bill.

"Any attempt to target the vulnerable in Wisconsin through assisted suicide will be resisted with every fiber of our being," said Peggy Hamill, state director of Pro-Life Wisconsin. "Assisted suicide, no matter how compassionate it may seem on the surface, is nothing more than a cruel lie. To the terminally ill, it tells them that there is no meaning to their life and that when they become a 'burden' to others suicide is the easiest answer for everyone. It also robs them of something integral to the human spirit – hope. Real compassion takes time and commitment. It means standing by someone and bearing their burden."

Senate Bill 151, authored by Senator Fred Risser (D-Madison) and Representative Frank Boyle (D-Superior), would "permit certain individuals to make written requests for medication for the purpose of ending their lives." It would legalize assisted suicide for people over the age of 18 who have a "terminal disease" and who make a written request to their attending physician for medication to kill themselves. A physician who refuses to participate in the assisted suicide must make a good faith attempt to transfer the patient to another physician whom he or she knows will help kill the patient. If the physician does not make an attempt to transfer, he or she may be charged with "unprofessional conduct."

"In a stark denial of reality, the bill states that requesting and taking prescribed medication to end your life does not constitute 'suicide,'" said Hamill. "If this isn't suicide, I don't know what is. Pro-lifers will stand strong on Wednesday to expose the deadly truth about this legislation. We will send a strong message to our elected officials that we will not allow the state to sanction the destruction of the vulnerable disabled, elderly, depressed or other marginalized lives around us," said Hamill.

In the State of Oregon, where assisted suicide is legal, Kaiser Permanente Northwest HMO has not merely permitted doctors to assist in patient suicides – it has actively solicited its doctors to participate in this deadly practice. In August of 2002, a Kaiser executive e-mailed a memo to more than 800 Kaiser doctors recruiting PAS-doctor volunteers. According to Portland psychiatrist Gregory Hamilton, MD, this email represents the first step down the slippery slope of killing patients to save money.

"In an age of soaring healthcare costs and cutbacks, how much longer until the 'right to die' becomes the 'duty to die?'" said Matt Sande, Pro-Life Wisconsin's Director of Legislation. "How much longer until those considered a 'burden' on society are systematically denied healthcare and life-saving measures in order to cut costs? The great state of Wisconsin can do better than assisted suicide."

A 2002 study of the impact of Oregon's "Death with Dignity Act" revealed that ninety percent of Oregon assisted-suicide patients change their minds. According to Dr. Susan Tolle, director of the Center for Ethics in Health Care at Oregon Health and Science University and head of the study, most people who ask their doctor about assisted suicide are simply depressed or fearful of pain. If properly counseled and treated, 90% choose to continue living.

"Right to die" forces routinely speak of patients dying in intractable pain. They call killing oneself a "basic human right" that should be constitutionally protected. Yet medical studies show that virtually all pain can be alleviated at the end of life. A study by the World Health Organization found that 95 to 100 percent of the pain experienced by people at the end of life can be adequately controlled.

"Instead of killing the pain, these 'right to die' activists focus on killing the patient," said Sande. "Few of them seem enthusiastic about educating healthcare professionals about the amazing advances in palliative care."

The public hearing will take place in Room 411 South of the State Capitol Building at 10:00 a.m.